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FISCAL IMPACT STATEMENT

LS 7054
BILL NUMBER: HB 1128

NOTE PREPARED: Dec 27, 2002
BILL AMENDED:

SUBJECT: Health Provider Reimbursement.

FIRST AUTHOR: Rep. Pelath
FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X **GENERAL**
X **DEDICATED**
FEDERAL

IMPACT: State & Local

Summary of Legislation: This bill specifies certain requirements for an insurer or a health maintenance organization in adjusting subsequent claims to obtain reimbursement for an overpaid claim. The bill prohibits a denial or limitation of coverage for a preauthorized service by an insurer or a health maintenance organization except in certain circumstances. The bill also specifies requirements of reimbursement by an insurer or a health maintenance organization for certain services.

Effective Date: July 1, 2003.

Explanation of State Expenditures: This bill will tend to increase health care costs for health maintenance organization plans and group insurance plans. The bill has three components: (1) claim overpayment adjustments must be made within six months and include a detailed statement of reason for adjustment, (2) payment for a preauthorized service cannot be denied retroactively unless certain conditions are met, and (3) requires insurer to reimburse a provider for all services specified on a claim form and each surgical procedure performed in a single operation, and it also specifies that an insurer cannot establish one rate for multiple procedure operations.

1) Claim Overpayment Adjustments - Currently, insurers are not required to provide a detailed listing of what procedure was overpaid, when the procedure was performed, or identifying information regarding the patient. This bill requires additional information be included in the notice of fee adjustment in subsequent claims. This requirement is expected to have minimal impact on health care costs.

2) Retroactive Denial of Payment - Under current practice insurers may deny payment for service if certain conditions are not met. Examples include when a physician was granted preauthorization, but the hospital

did not request preauthorization; and a procedure was authorized for one date and performed on another. The cost of this provision is undeterminable at this time. Cost will increase according to the difference between the number of claims that would have previously been denied and the number that do not meet conditions of denial as set forth in this bill.

3) Reimbursement for All Services - This provision requires that an insurer reimburse a provider for all covered services provided to an insured individual. Under current practice an insurer may choose not to reimburse a provider for non-covered services or surgical procedures performed in addition to the original procedure. In addition, an insurer may currently set one rate for all surgical procedures performed in a single operation. This bill restricts insurer cost containment options and would tend to increase health plan costs by making it more difficult to influence medical practice patterns. The extent of the increase is unknown and contingent upon whether insurers are required to pay duplicative costs associated with multiple surgical procedures performed during one operation, the reimbursement schedule for secondary procedures performed during an operation, and the extent that non-covered services that would have previously been denied are paid under the provisions of this bill.

Explanation of State Revenues:

Explanation of Local Expenditures: See *Explanation of State Expenditures*. This bill will tend to increase health care costs for health maintenance organization plans and group insurance plans.

Explanation of Local Revenues:

State Agencies Affected: All that use health maintenance organization plans and group insurance plans for employee health care.

Local Agencies Affected: All that use health maintenance organization plans and group insurance plans for employee health care.

Information Sources:

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